

State of Arizona



Comprehensive HIV Prevention Plan 2007 – 2011

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of HIV, STD and Hepatitis C Services

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Section 1 - Preface

HIV/AIDS prevention community planning processes in Arizona were streamlined and refocused since the last version of this document. The changes described in this Plan allow for cohesion of statewide planning and for regionally-specific input and action. Arizona now has a single Community Planning Group comprised of representatives from all parts of the state. These members are experts in areas relating closely to HIV prevention, and community members living with or impacted by HIV. Three regional groups covering Northern, Southern and Central Arizona receive Health Department support to contribute input to the statewide body and to work in their specific regions to further HIV prevention messages and activities.

Another major shift that has impacted Arizona's HIV Prevention activities took place within programs at the Arizona Department of Health Services (ADHS). The HIV/AIDS, Sexually Transmitted Disease and Hepatitis C programs have been integrated. Support staff integration and partial physical relocations are completed, and the more day-to-day opportunities presented by this shift are being explored and expanded. Of particular note to the HIV Prevention team is the fact that the new Chief for the Office of HIV, STD and Hepatitis C Services is Judy Norton. Judy was with the HIV/AIDS program when Arizona started its first HIV community planning process.

This Plan contains a look back for a historic overview of HIV prevention community planning in our state, a summary of current HIV prevention processes and activities throughout Arizona, and a glimpse ahead toward planning for the remainder of this planning cycle and beyond. Where applicable, the national Community Planning Goals and Objectives from the Centers for Disease Control and Prevention (CDC) are re-stated here in order to provide context for some planning activities.

A note on timing

While this Plan addresses the full 2007-2011 planning cycle, the present draft of the document was completed in early 2008. **Please note** that information for 2007 is worked into the body of this text rather than in a separate update. Annual updates for the next four years will be added separately.

After addressing shifts in community planning processes and integration activities, ADHS staff members took additional time to explore the implications that both levels of change might have for statewide and regional planning activities. While the actual writing of this Plan was delayed, the additional time has helped all those involved to refocus and re-create HIV prevention planning goals.

Section 2 - Acknowledgements

The present document is Arizona's Comprehensive Plan for HIV Prevention for 2007 through 2011. This Plan emerges from a backdrop of a community planning vastly different from the beginnings of the previous planning cycle.

Our Plan is dedicated with gratitude to every person who has added their voice, their experience and their hard work to the reformulation of HIV prevention community planning in our state.



As current Chairs and regional staff we thank the members of our communities for their input, assistance and dedication.

- ◆ Erica Ferguson, ADHS employee and State co-chair for the PPGA
- ◆ Larry Stähli, community member and PPGA Community co-chair
- ◆ Mary Leasor, staff member for The Central AZ HIV Prevention Advocates
- ◆ Miguel Soto, staff member for The Southern AZ HIV Prevention Planning Group
- ◆ Christina Jackson, staff member for the Northern Arizona HIV/AIDS Forum

Section 3 - Introduction

Arizona: the name conjures up images of the massive Grand Canyon, the gunfight at the OK Corral in Tombstone, old Wild West tales by Zane Grey, Indian tribes and vast expanses of desert.

In actuality, Arizona is all these things and more. Elevations range from 70 ft above sea level by the Colorado River at the Mexican Border to Mount Humphrey's 12,633 ft summit in the San Francisco Peaks north of Flagstaff. The marsh lands along the lower Colorado River are habitat to migrating waterfowl. Much of the southern and western portions of the state are in the Sonoran Desert, while the northeastern portion is part of the Colorado Plateau - a high desert. The world's largest ponderosa pine forest extends across the north central Arizona. Mountain ranges crisscrossing the state contain "sky islands", isolated mountain peaks where a drive from the base to the peaks spans climatic regions equivalent to going to northern Canada in an hour. Rainfall across the state averages less than 10 inches per year with Yuma receiving only 3 inches annually to some higher mountain peaks getting more than 20 inches of rain. Most rainfall occurs during the summer monsoon of July and August and during the winter in December through February. Flagstaff actually receives more snow (95 inches) annually than the "snowy" Buffalo, New York. Temperatures in the state range from a record low of 40F below in Hannigan Meadow to a high of 128F in Yuma. In many low desert communities, highs of 110F and above are common during the summer months.

Arizona is the sixth largest state with a land mass of 113,575 square miles. Within this area are just 15 counties ranging from Santa Cruz, the smallest at 1,236 square miles (about the size of Rhode Island) to Coconino County, the second largest county in the United States at 18,661 square miles (about the combined size of New Hampshire & Vermont). Approximately 27% of Arizona is under the jurisdiction of local Indian tribes, 57% is under state and federal jurisdiction and 16% is privately or corporately owned. Tribal lands range from the 25,000 square mile Navajo Reservation - the nation's largest reservation and the nation's largest tribe, to the 85-acre Tonto Apache Reservation near Payson. There are 21 legally recognized indigenous tribes in Arizona. Tribal lands are separate jurisdictions having their own tribal governments, laws and law enforcement units. Federally owned lands include six national forests: Kaibab, Coconino, Apache-Sitgreaves, Prescott, Tonto, and Coronado. There are twenty three national parks, monuments and historic sites in Arizona from Grand Canyon National Park and Monument to Canyon de Chelly with its Anasazi ruins. The Bureau of Land Management controls the remainder of the federal lands. Lease holds for grazing and mineral exploration are under this agency's control. State lands are comprised of state parks and recreation areas, as well as, lands that the state can sell for the school trust.

The human landscape in Arizona goes far back in time with remnants of early habitation as far back as 10,000 years ago. Comparatively more recent human activity can be seen in the ruins of cultures such as the Anasazi, Sinaqua, Salado and Hohokam peoples: these date back more than 1,000 years. Cliff dwellings of the Anasazi are found in Canyon de Chelly. The Sinaqua peoples left ruins at Tuzigoot and Montezuma Castle Nation Monument. Oraibi on the Hopi Reservation is believed to be the oldest continuously inhabited place in the United States dating from 1100 CE. The Hohokam inhabited what is now the metro Phoenix area and present day irrigation systems still follow the Hohokam canals. The Spanish conquistador Coronado first entered the

present day state of Arizona near the Coronado National Monument searching for the Seven Cities of Gold. He encountered the present day Indian inhabitants of the state. The first European settlement in the state was in 1752 at Tubac in Santa Cruz County by the Spanish. In the late 1880's the state was attractive for its mineral resources. Mining became the prominent industry and boomtowns developed. Some prospered, but now numerous ghost towns are scattered across the state. The state's most significant growth started in the early 20th century when major dam projects were built across the Colorado, Salt, Gila and Verde rivers. The newly created lakes formed provide for irrigation, hydro-electric power and recreational opportunities. For a landlocked state, Arizona now has the second highest per capita boat registration in the US.

Arizona is now the second fastest growing state in the country. US Census Bureau data estimated that in 2006 the state's population was 6,305,775. Approximately 80% of the state's population lives in just three counties: Maricopa, Pinal and Pima. Phoenix is now the fifth largest city in the United States and is more suburban in nature than typical urban centers such as New York, Los Angeles, Chicago and San Francisco. The Phoenix metro area encompasses most of eastern Maricopa County and northern Pinal County. Pima County contains Tucson. Close to 90% of all persons living with HIV/AIDS in Arizona live in one of the two metropolitan areas.

Of Arizona's residents, 29% are Hispanic or Latino, close to 4% are Black or African American, just under 5% American Indian, 2% Asian, less than one percent Hawaiian and Pacific Islander, and 60% White or Caucasian (not of Hispanic origin). There is also a large population of mainly Hispanic and largely monolingual undocumented persons in the state. These individuals reside mainly in the metropolitan areas and tend to delay entry into health care due to suspicions and fears relating to their immigration status.

With thanks: Material for this Introduction and for descriptions of the three regions used later in this Plan was submitted by Larry Stähli. Longtime Arizona resident and PPGA community co-chair as of the writing of this document, Larry expressed a desire to use his knowledge of the Grand Canyon State to set the backdrop for HIV prevention activities in our part of the Southwest.



Section 4 – Arizona’s HIV Prevention Community Planning process and PIR

Definitions

The community planning process for HIV/AIDS prevention operates in many forms nationwide. Group structures and specific processes vary across the country. Each community planning group works with its state health department by following the HIV Prevention Community Planning Guide (hereafter “the Guidance”), a document produced by the Centers for Disease Control and Prevention.

From the Guidance, Community Planning is introduced as follows:

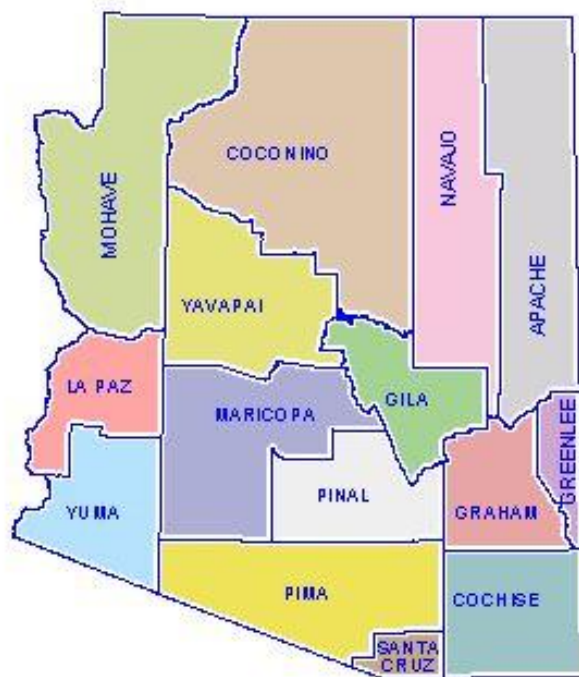
CDC expects HIV prevention community planning to improve HIV prevention programs by strengthening the: (1) scientific basis, (2) community relevance, and (3) population- or risk-based focus of HIV prevention interventions in each project area. Beginning in 1994, CDC changed the manner in which federally-funded state and local level HIV prevention programs were planned and implemented. State, territorial, and local health departments receiving federal prevention funds through CDC were asked to share with representatives of affected communities and other technical experts, the responsibility for developing a comprehensive HIV prevention plan using a process called HIV Prevention Community Planning. The basic intent of the process has been threefold: to increase meaningful community involvement in prevention planning, to improve the scientific basis of program decisions, and to target resources to those communities at highest risk for HIV transmission/acquisition. The CDC remains committed to supporting HIV prevention community planning.

Each year, the CDC distributes funding to state health departments and other jurisdictions for HIV prevention programs.

Historic overview of the Community Planning process in Arizona

In 1994 the formal community planning process for HIV prevention mentioned above started in Arizona. At that time, Arizona was organized into 3 planning regions with Northern, Central, and Southern community planning groups (CPGs) operating with separate meeting schedules and planning cycles. In the late 1990’s, an American Indian prevention group also emerged to address specific needs of native populations, build capacity, provide support to its members, and support their full participation in Arizona’s three CPGs. The Arizona American Indian HIV Prevention Task Force is still meeting today and there is cross-membership between it and the state and regional community planning groups.

The Northern, Central, and Southern CPGs submitted annual HIV prevention plans or plan updates to ADHS. ADHS then combined the three regional plans into the State plan mandated by the CDC. While this situation had its strengths in terms of specific regional input, the resulting “State plan” lacked cohesion and remained region- rather than state-focused.



Northern Arizona	
Mohave	Coconino
Yavapai	Navajo
Apache	Gila
Central Arizona	
Maricopa	
Pinal	
Southern Arizona	
La Paz	Yuma
Pima	Santa Cruz
Cochise	
Graham	Greenlee

Arizona showing the division of the fifteen counties for regional planning

In 2002-2003, ADHS began to encourage the three CPGs to synchronize and coordinate their planning cycles and make other procedural shifts toward a more unified, streamlined planning process. HIV/AIDS Office prevention staff and regional state-appointed co-chairs started meeting on a monthly basis to share resources and planning strategies. By the time that CDC issued its 2004-2008 HIV Prevention Funding Application, *Advancing HIV Prevention: Strategies for a Changing Epidemic*, and the new *Community Planning Guidance*, ADHS community planning staff had already laid the groundwork for a possible move to a statewide planning group process. These potential changes were informed by increasingly burdensome CDC requirements for health departments and planning groups, the desire for a more cohesive overall planning process, and by the epidemiology of HIV in this state. Epidemiologic data showed continuing and increasing urbanization of the epidemic and strongly supported a statewide approach to HIV/AIDS prevention.

The HIV Prevention Planning Group of Arizona (referred to hereafter as the PPGA) emerged as the new statewide Community Planning Group. The PPGA is the centralized planning authority for HIV prevention in Arizona and is the architect of the comprehensive statewide prevention plan. ADHS hired a Community Planning Coordinator in June of 2005; this individual serves as the PPGA's state co-chair and is the ADHS liaison to the regions. The three regional planning groups (referred to as RPGs) remain in place and act as critical advisory bodies to the PPGA. As they are no longer bound by many of the stringent CDC planning and reporting requirements, the RPGs have been able to take on key roles for HIV prevention information and activities on the regional and local level.

**ADHS GUIDING PRINCIPLES
FOR COMMUNITY PLANNING IN ARIZONA**

**Commitment to the fundamentals of Community Planning
as outlined in CDC's 2003-2008 HIV Prevention
Community Planning Guidance**

**Recognition of Regional Planning activities as the
foundation for statewide planning efforts**

**Affirmation of the independence of
Regional Planning Groups**

Consensus decision-making

Structure and process

These Guiding Principles are taken from Statewide Guidelines for HIV Prevention Community Planning in Arizona, a guidance published by ADHS in October of 2005. The full document is included with this Plan as Attachment C.

As of the writing of this document, Arizona has entered the second year of the 2007-2011 Planning Cycle. This is the first five-year cycle for the state, and structural changes continue to be made. With prioritized populations set and grants in place (see Section 7) the main focus for early 2008 has been the drafting of this Plan as a working document for the PPGA and regions.

PPGA procedures

Full group meetings for the PPGA are scheduled quarterly (March, June, September, December) in a central Phoenix location. The group uses a meeting room made available by a local AIDS organization. Meetings are on Mondays from 10:00 am to 2:00 pm to allow travel time for those outside of the Phoenix area. The PPGA is currently exploring options for tele- or web-conferencing. Work and communication between full group meetings is conducted via email per group preference – to date all members have reliable access to the internet.

Decision-making within the PPGA is carried out using a consensus process. Consensus, as understood in the PPGA, is achieved when all members present state that they are comfortable with, agree with, or are prepared to step aside from a differing view to allow the group to move forward on a decision. All members present must be prepared to be accountable for the decision, with the noted exception of any who had removed themselves due to conflict of interest. A consensus model affirms the equal right and responsibility of all members to participate fully in reaching group decisions. All members are eligible to participate in decision-making. Any member may choose not to participate in consensus, including those persons with an identified conflict of interest. For situations when a consensus agreement is challenging, PPGA has specified a provision for voting as needed.

To date, incoming PPGA members receive an orientation and membership materials from the state-appointed co-chair. There are plans underway for a New Member

Orientation now that vacancies and new arrivals have changed the original slate of members. Procedures concerning conflict of interest, term limits, committees and more can be found in the PPGA Bylaws (Attachment A)

Please note that specific plans for PPGA and regional membership recruitment will be addressed in Section 8.

PPGA Membership

GOAL ONE: Community planning supports broad-based community participation in HIV prevention planning.

The PPGA addresses this first goal from the CDC Guidance by creating as diverse and representative a group as possible. PPGA membership encompasses the expertise of selected individuals from each region, voices from at-large members representing groups at risk for, affected by, and infected with HIV, and key personnel from Arizona programs or departments that have a significant interface with the HIV epidemic. The membership structure of the PPGA was based on input from ADHS and from statewide planning meetings that took place prior to the move to a statewide group. At present a complete membership roster totals 32. Adjustments to the agency or program representative list are possible and may be made as needed to meet emerging needs. The numbers of at-large members and regional representatives is expected to remain constant.

Note that each member is a decision-making (voting) member. While the meetings are open and there are other individuals who attend regularly or occasionally, the PPGA has decided to recognize the core of 32 persons as decision-makers.

A full membership roster of the PPGA includes the following:

- One staff member from ADHS (the HIV Community Planning Coordinator, serving as the State-appointed CPG co-chair)
- Staff members from each regional group (total of three)
- Three representatives from each regional advisory group (total of nine)
- Representatives from a variety of entities related to HIV/AIDS in Arizona:
 - STD Program at ADHS
 - Inter Tribal Council of Arizona
 - HIV/AIDS Care and Services (total of two Care representatives)
 - Department of Corrections
 - HIV program at the Arizona Department of Education
 - ADHS Hepatitis C Program
 - Behavioral Health Services at ADHS
- Eleven at-large community members

This original composition for the statewide CPG was determined with combined input from ADHS, the former regional CPGs, and key stakeholders. Applications for at-large members were solicited by ADHS and those members were chosen based on their contribution(s) to the diversity of the group.

As time passes and vacancies arise, openings in the professional representative positions are filled by ADHS, regional representatives are chosen by the regional group involved and at-large members are selected and invited by the Membership Committee.

Parity, Inclusion and Representation: PIR in the PPGA

“Parity, Inclusion, and Representation” (referred to as PIR) is a fundamental component of the HIV prevention community planning process. This concept is intended to ensure that planning groups include a diverse group of members who truly understand and represent those most affected by the epidemic. PIR also states that every member should be able to participate and have a voice in what happens in the meetings.

Parity: Community information-sharing

Parity means that all members can participate and carry out planning tasks. To achieve parity, each member must have an understanding of community planning, have opportunities to enhance community planning skills, and have a voice in making decisions.

The PPGA ensures parity through:

- Distributing agendas and/or other relevant information prior to meetings
- Ensuring that members who may not have experience with the CPG process are given orientation and ongoing support in learning the PPGA culture
- Ensuring that decisions are made publicly at full group meetings
- Consistently providing an opportunity for all voting members to participate in discussions before decisions are reached
- Providing leadership that involves, includes and encourages diversity
- Utilizing culturally congruent and consistent materials

Inclusion: Community Content

Inclusion is defined as involving members in the meeting process in a meaningful way and ensuring that members have an active voice in decision-making. An inclusive process assures that the views, perspectives, and needs of all HIV-affected communities are included.

The PPGA ensures inclusion through:

- Recruiting and maintaining a voting membership that accurately represents the communities most impacted by HIV/AIDS throughout the state
- Maintaining a diverse membership that includes representatives from many realms of the community (AIDS organizations, business coalitions, private/public institutions, etc.)

Representation: Community Participation

Representation is the act of serving as an official member reflecting the values, beliefs, and behaviors of a specific demographic or community. Members should be able to participate objectively in the overall prioritization process and either emphasize or set aside personal priorities as informed by the greater good of the statewide community. It

should be noted that a person may, from professional or personal experience, be able to represent a community or reality not their own.

The PPGA ensures representation through:

- Requesting information from all members regarding each person's affiliations, individual community and/or group membership(s), and population(s) they are able to represent
- Matching as closely as possible the representations of the members to the epidemiology of the HIV/AIDS epidemic in Arizona
- Creating and maintaining structures that provide for internal and external accountability

PIR Data from the PPGA

As Arizona's official community planning group, the PPGA is expected to mirror as closely as possible the demographics of HIV in the state. The following tables, adapted from the 2006 Internal Progress Report/IPR and from member applications, show demographics and areas representation per member report.

The first table shows percentages of the full membership in the areas of member category, residence (in the three state regions) and answers to "for which group(s) are you able to advocate for/represent as a PPGA member?" The second table compares group demographics with statewide epidemiologic numbers for key demographic areas.

Membership type:	Percentage	Advocating for: (able to mark more than one)	Percentage
Staff or program representative	28%	Gay men/Men who have sex with men	70%
Regional Representative	38%	Youth	20%
At-large member	34%	Injection drug users	45%
Resident of:		Substance users/abusers	60%
Northern AZ	13%	HIV positive people	75%
Central AZ	59%	Faith communities	15%
Southern AZ	28%	Other **	25%

* **NOTE** that staff members, because they are employed to work with community planning or invited to represent a specific agency/issue, are not included here

* "Other" responses: rural, "affected", women, women of color, Native American, transgender

PPGA compared with the HIV epidemic in Arizona
Using membership data as reported in the 2006 Interim Progress Report

Gender	PPGA	Arizona Epidemic
Male	53%	86.5%
Female *	47%	13.5%
Race/ethnicity	PPGA	Arizona Epidemic
American Indian/ Alaska Native	6%	3.6%
Asian/Pacific Islander	0	1%
Black	6%	11%
Hispanic	19%	23%
White	69%	60%
More than One Race	0	1%
Unknown	0	not available
HIV Risk and Status	PPGA	Arizona Epidemic
MSM	41%	60.3%
MSM/IDU	?	8.9%
IDU	?	13%
High Risk Heterosexual	?	10.3%
Other **	?	1.7%
No Reported/Unknown Risk	58%	5.8%
(Self-disclosed) HIV+	1%	n/a

* "Female" count includes one MTF transgender PPGA member

** "Other" = Hemophilia/Transfusion and Blood Products/Transplant Recipient

Discussion and planned changes to address PIR

These tables and related information from annual reporting on community planning indicate both areas in which the PPGA reflects strong PIR as well as areas of potential improvement. The PPGA structure balances membership categories well, with a balance

between staff or “experts” representing a given focus and individuals representing their regions or priority groups. The proportions of members from the three regions echo the distribution of HIV in the state – most in the Phoenix area, followed by Tucson/Southern counties then the more sparse Northern counties.

The most apparent areas of focus for ongoing membership recruitment are:

- Men, especially gay or MSM individuals
- Black/African American individuals
- Asian/Pacific Islanders (as of this Plan draft staff are not aware of any API individuals active in HIV groups statewide)
- Individuals reporting a personal history of or experience with injection drug use; other members do report non-injecting histories and/or work closely with IDU populations

The final bullet point here highlights the fact that, using the first table as an example, the “advocating for” responses may include both primary and secondary representation (a member may, with professional or other life experience, have stated that they are able to represent a group or groups outside of their own demographic). Community planning staff have noted that current reporting formats do not always capture the nuances in this area.

Attempts to chart PPGA membership as related to HIV risk categories from state epidemiology data clearly showed the need to rework membership information gathering: simply stated, there is not a record currently that shows responses in the same format, hence the question marks in the second table. In early 2008 the state co-chair will work with PPGA members on improved data-gathering.

Since the 2006 IPR (data in these tables), there have been several changes in the PPGA. Member departures, vacancies and new member arrivals have occurred. Upcoming updates will reflect these changes. Note that the first membership roster for the PPGA called upon a good majority of the individuals known to be concerned with HIV prevention in the state at that time in order to create a full group. As openings occur now there is opportunity to seek out and work with new individuals and to focus on recruiting to fill PIR needs.

The initial slate of members for the PPGA came in part from the three regional planning groups. These groups and their important contributions to statewide planning are discussed next.

Regional Planning Groups: definitions, processes and PIR

Arizona’s three Regional Planning Groups, collectively referred to as the RPGs, reflect the beginnings of Community Planning in the state while also spotlighting current and future trends in HIV prevention activities. Although no longer official CPGs, they were maintained after the start of the PPGA and each group made the necessary changes to their missions and bylaws. In the start of the 2007-2011 planning cycle the regions played a crucial role in the prioritization process (to be outlined in Section 7).

The Regional Planning Groups are as follows:

- The Northern Arizona HIV/AIDS Forum (referred to as the Forum)
- The Central AZ HIV Prevention Advocates
- The Southern AZ HIV Prevention Planning Group (known as SAHPPG)

The map on page 9 shows the counties for each group.

The 2005 Statewide Guidelines for HIV Prevention Community Planning in Arizona from ADHS describes membership for the RPGs as follows:

Regional Planning Group membership should reflect and represent the communities in their jurisdiction/region at increased risk for HIV infection, including those persons living with HIV disease.

Overall group processes including bylaws, committees, and meeting schedules are set by each RPG based on ADHS guidelines and logistics in each area. The Central and Southern groups focus exclusively on HIV prevention, while the Northern body combines care and prevention.

Each region is unique due in great part to the geographic diversity in the state. The remainder of this section contains general information about each region that will be helpful in understanding areas of HIV prevention focus.

Northern RPG

The northern region is comprised of six counties: Mohave, Yavapai, Coconino, Gila, Navajo and Apache. The area stretches from the border with California and Nevada approximately 300 miles east to the New Mexico state line. The extreme north - south axis is 235 miles extending from the Utah border to Cochise County in the Southern Region. It contains a total of over 66,000 square miles (close to the size of Washington State) and a population of just over 789,000.

The largest community in the region is Flagstaff with 62,000 residents. Lake Havasu City has a population of 54,600 and Kingman has 39,900 persons. Other communities in the region with populations over 10,000 include Sedona, Prescott, Payson, and Safford. Most of the Northern region is classifiable as either rural or frontier. The sparse population density poses many challenges both for prevention and care of persons living with HIV.

African Americans make up 1% of the region's population. American Indians constitute 77% of the population of Apache County and 48% of the population of Navajo County. Coconino County is 28 % American Indian. Hispanics account for 10% of the populations of Coconino, Yavapai and Mohave counties.

Key HIV prevention issues in the Northern region include: rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density (as much of the region is considered frontier), transportation and access to resources.

Central RPG

The central region contains just two counties: Maricopa and Pinal. The region is approximately 125 miles east to west, and 110 miles from north to south. It contains a total of 14,596 square miles (a little larger than Massachusetts, Connecticut and Rhode Island combined) and a population of 4,092,550 persons, most residing in the metro Phoenix area. Phoenix is the largest city in the state and fifth largest in the country with a population of over 1,500,000. It is also the state capital and County seat of Maricopa County. The adjoining cities of Mesa, Glendale, Scottsdale, Chandler, Gilbert and Tempe add significantly to the population of this large metropolitan area. As with other areas of the state outside of the metro areas, the population is rural and sparsely populated.

African-Americans constitute 4% of the population of Maricopa County. American Indians constitute 8% of Pinal County and 2% of Maricopa County. Hispanics constitute 30% of the population of Pinal County and 25% of the population of Maricopa County. Asian/Pacific Islanders constitute 2% of the population of Maricopa County.

Key prevention issues in the Central region are ethnic/racial disparities, especially within the African American community, stigma, a lack of prevention education in schools, lack of a strong prevention marketing messages (social marketing), and access to care issues.

Southern RPG

The southern region is comprised of seven counties: La Paz, Yuma, Pima, Santa Cruz Cochise, Graham and Greenlee. The area stretches from the Colorado River eastward to the New Mexico state line for a total of 340 miles. On the north-south axis the average width of the region is 170 miles. The region contains 33,000 square miles (a little larger than the state of South Carolina) and a population of 1,424,000. The southern boundary of the region is with the Mexican state of Sonora and a small portion of the region's western boundary is with Baja California del Norte. The largest city in the region is Tucson with a population of 535,000. Yuma, the second largest community, has 92,000 inhabitants. Other communities in the region with populations over 10,000 include Sierra Vista, Nogales, Oro Valley and Marana.

African Americans constitute 5% of the population of Cochise County, 3% of the population of Pima County and 2 % of the population of Yuma County. African Americans constitute less than 1% of the other counties in the region. American Indians constitute 13% of the population of La Paz County and 3% of the population of Pima County. Asian/Pacific Islanders constitute 2% of the population of Pima County. Hispanics account for 28% of Graham County and 43% of Greenlee County.

Hispanics constitute 81% of the population of Santa Cruz County, 50.5% of the population of Yuma County, 30% of the population of Cochise & Pima Counties, and 22.4% of the population of La Paz County.

Key HIV prevention issues in the Southern region include rural concerns, such as access to care, testing opportunities and prevention education. Other concerns are bilingual services/materials and a lack of IDU prevention programs.

Section 5 – Epidemiologic Profile

Material in this section was submitted by Steven (Rob) Bailey, Capacity Building Epidemiologist Specialist for the ADHS Office of HIV, STD, and Hepatitis C Services. The following is an adaptation of the 2007 HIV/AIDS Annual Report with updates included prior to submittal of this Plan.

General Comments

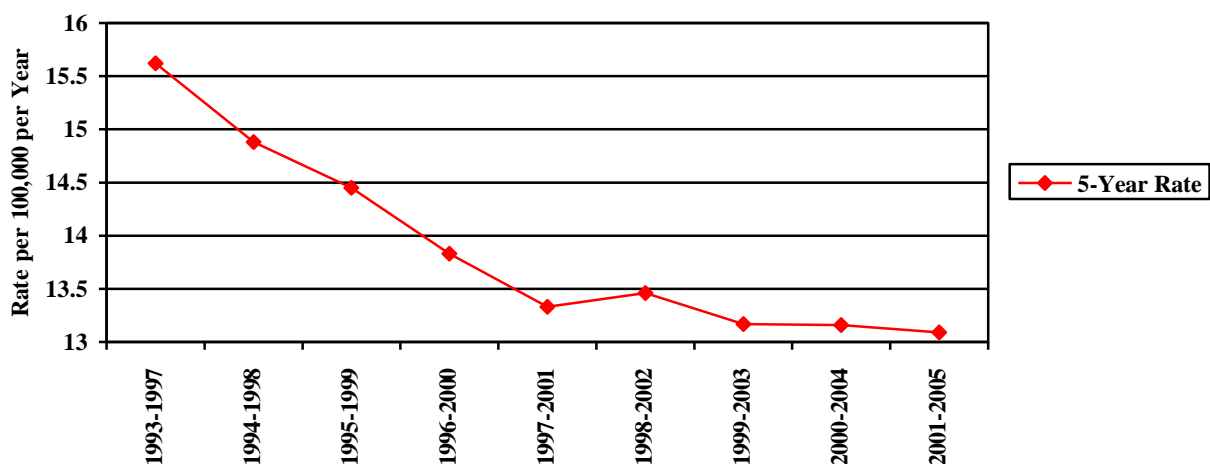
In Arizona's HIV/AIDS reporting estimates of incidence are based upon the sum of new HIV cases, and new AIDS cases which were not diagnosed as HIV infections in any prior calendar year. These cases are referred to as emergent cases and are used as an estimate of incidence. Cases of HIV/AIDS can only be counted as emergent in the year they were first diagnosed with HIV infection. Persons who were emergent as HIV and diagnosed as AIDS in the same calendar year are counted as emergent AIDS to avoid double counting. This method is the most straightforward method available for estimating incidence.

This report includes current (February 2007) estimated prevalence, 2005 reported emergent case counts, and the 2005 population estimate for each county or region. For comparison to prior period prevalence or incidence, please refer to previous annual reports. Incidence estimates for the 5-year reporting timeframes (1996-2000 and 2001-2005) used in this report are expressed as annualized rates for purposes of valid comparison with the 5-year timeframes in prior annual reports, or single-year annual rates provided elsewhere. These annualized 5-year rates may be regarded as the average annual rate across the 5 years in the reporting timeframe.

Current Data

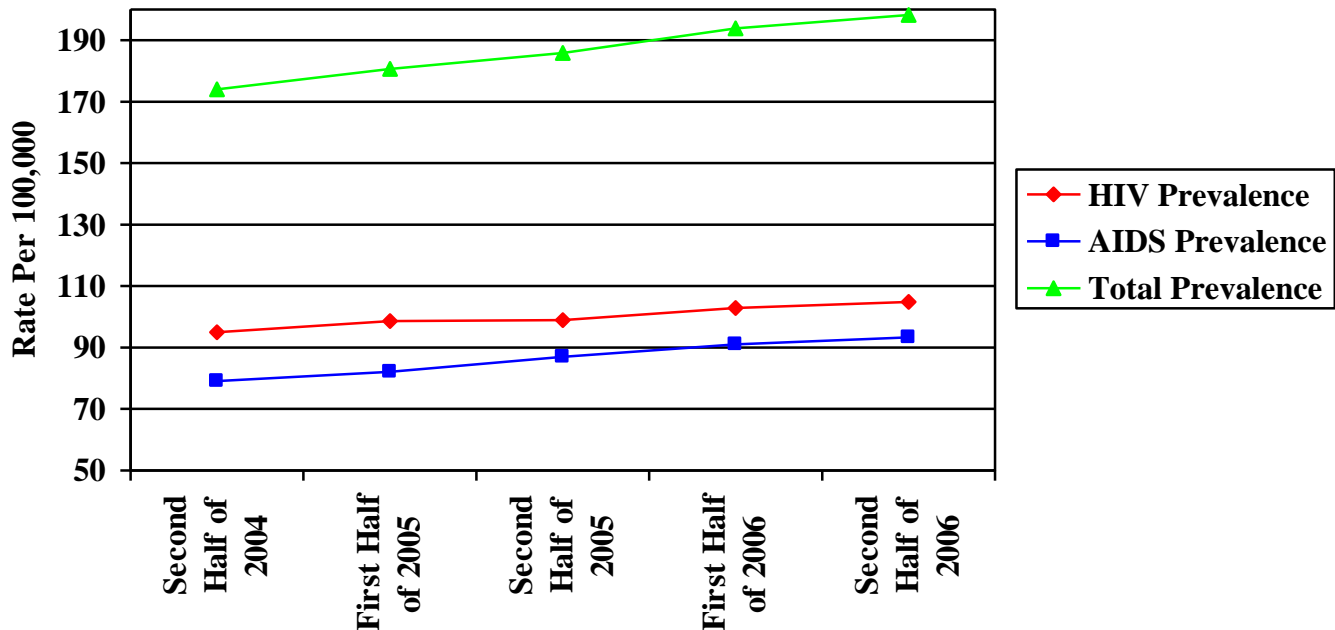
After tracking trends in emergent HIV infection, and prevalence for 3 years, a sufficient body of data now exists for trend patterns to be discussed. The State of Arizona is currently experiencing some of the most rapid population growth in the nation. Most of that growth is taking place in the Phoenix Metropolitan area. Recent trends show the 5-year HIV/AIDS emergence case rate has been declining. 5-year average case rate trends are shown in Figure 1 below. 5-Year average rates are not as subject to year-on-year variance as annual rates.

Figure 1: Arizona 5-Year Emergent HIV/AIDS Case Rate Trend



While emergent rates were declining, HIV/AIDS prevalence rates have been rising. The increase in prevalence rates appears to be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced HIV-related death. Prevalence Trends are shown in Figure 2 below.

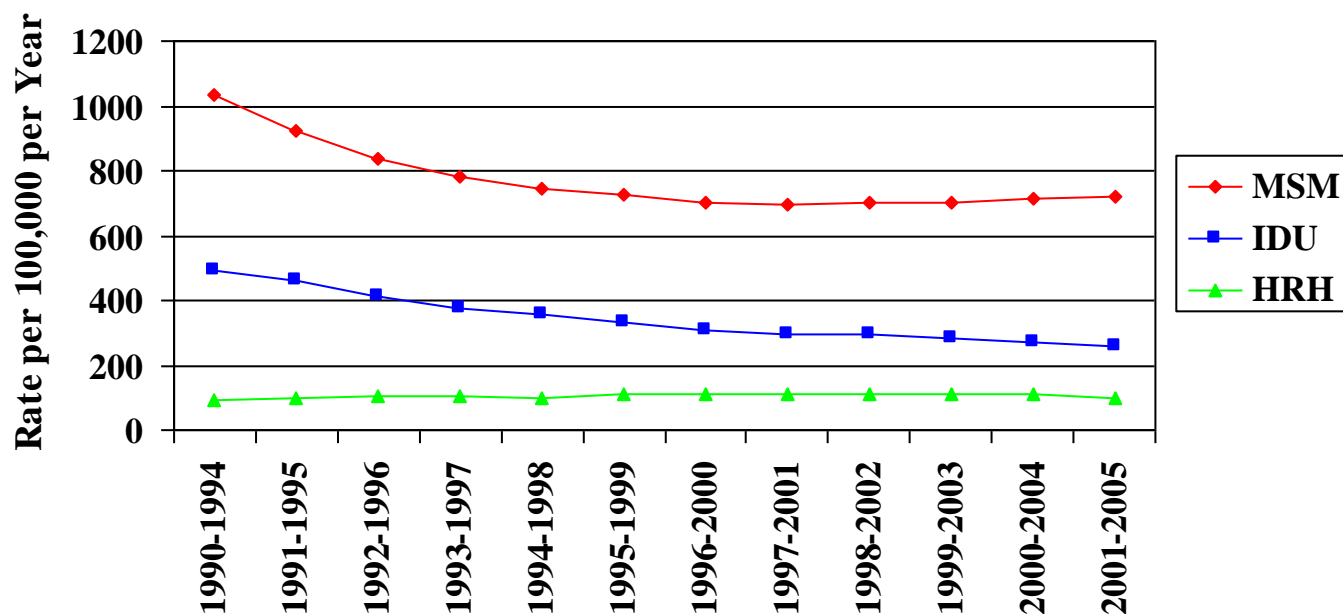
Figure 2: Arizona HIV/AIDS Prevalence Rate Trend



If current prevalence trends continue, within the next 3 to 5 years the number of persons living with AIDS in Arizona will surpass the number of persons with HIV infection who have not been diagnosed with AIDS. Because the burden of HIV-related disease is greater among persons with AIDS, treatment, utilization, and continuity of care will become increasingly critical issues.

While emergent rates have been declining, that trend has not been consistent across all risk categories. Rates of emergent HIV infection among persons reporting injection drug use (IDU) have declined consistently, and among persons reporting high-risk heterosexual activity (HRH) they seem to have remained level since 1990. But among men who have sex with men (MSM) emergent HIV rates declined to a low in 1999 and have risen slightly since then. These trends are shown in Figure 3 below. Because of different rate patterns between different risk groups, the proportion of the HIV epidemic in MSM is increasing. The proportion of emergent cases that are MSM-related has risen from a low of 60% in 1995 to 73% in 2006. These data, together with study data not reported here, suggest a measurable resurgence in the HIV epidemic in MSM, and may contribute to the slower decline of the emergent HIV/AIDS case rate since 1999.

Figure 3: Arizona 5-Year Emergent HIV/AIDS Rates by Reported Risk



Pediatric HIV Infection

In 2005 there were 9 cases of emergent HIV infection among children under age 13 in Arizona. This was a greater number than in any single year since 2000. Six of these cases (67%) were in African American children. African Americans constitute just 3.5% of the 2005 Arizona population. All 9 cases were due to mother-to-child transmission (vertical transmission). At the time of this report, the number of pediatric cases of HIV infection reported in 2006 is 3.

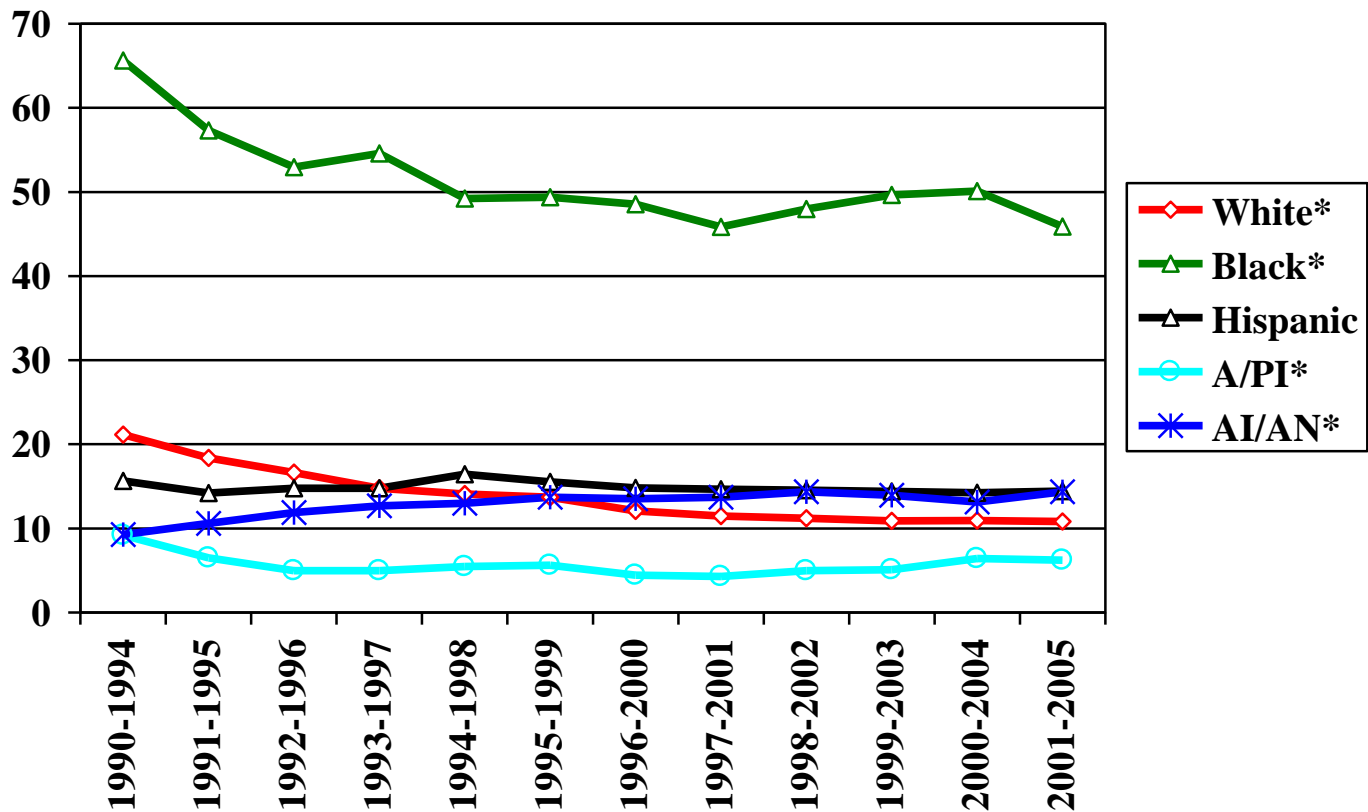
Urbanization of HIV

Rates of HIV/AIDS prevalence and emergence differ sharply between counties in Arizona that are primarily urban, and those that are primarily rural. At the time of this report, 86% of reported HIV/AIDS prevalent and emergent infections occur in urban counties that contain 76% of the state population. The average rate of HIV/AIDS emergent infection and HIV/AIDS prevalence in urban counties in Arizona is between 2 and 2.5 times greater than the average in rural counties.

Race/Ethnicity Disparities

Rates of HIV/AIDS prevalence and emergence differ sharply between African Americans and other race/ethnicity groups. African Americans are the only race/ethnicity group in Arizona that experiences such a severe disparity of HIV impact. Currently the emergent HIV/AIDS rate among African Americans in Arizona is more than 4 times that of White Non-Hispanics. This disparity is presented in Figure 4 below.

Figure 4: Arizona 5-Year Emergent HIV/AIDS Rates by Race/Ethnicity



Groups of Special Concern

Effective prevention policy focuses upon groups most adversely impacted by HIV/AIDS, or known to be at greater risk of transmitting HIV infection. In Arizona there is a clear and alarming impact of HIV/AIDS in the African American community. African Americans in Arizona experience an epidemic of HIV/AIDS that is at least a 3 times more severe than any other race/ethnic group. This disparity is more pronounced among African American women than among African American men.

In 2007 Arizona had a significant Syphilis outbreak. This emerging epidemic continues at this time. The link between Sexually Transmitted Disease (STD) and increased likelihood of HIV transmission is well established. For this reason, prevention effort among persons who experience an STD diagnosis, particularly those who are also HIV infected, should be a priority.

Highly Active Anti-Retroviral Therapy (HAART) has been extremely effective in preventing HIV-related death and disease by lowering HIV viral loads. High viral loads also increase the likelihood of HIV transmission. Linking persons living with HIV to HAART therapy through HIV primary is a critical element of prevention efforts. Current estimates are that nearly 40% of persons reported with HIV infection in Arizona are not receiving HIV primary care. Prevention effort among this group should be a priority.

Section 6 – Community Services Assessment

Per the CDC Guidance, a Community Services Assessment (CSA) describes the prevention needs of populations at risk for HIV infection, the prevention activities and interventions implemented to address these needs, and the service gaps that exist.

Arizona's most recent CSA was completed in 2005 and still reflected the previous configuration of three separate CPGs. As the move towards statewide planning was already underway the assessment was designed to be statewide; however, the process was rushed to meet the needs of the new planning cycle. Results, presented at the second meeting of the then-new PPGA, were found to be only minimally helpful for the prioritization process.

The full 2005 CSA is included as an appendix to this document. Highlights, feedback and plans for the next CSA are included in this section.

For the 2005 assessment ADHS contracted with the Phoenix-based Community Resource Associates. ADHS staff members worked with contractors Jim Fausel and Denis LeClerc to design a multi-perspective focus involving both qualitative (Nominal Group Technique, or NGT) and quantitative (survey) methodologies.

NGT is a structured variation of small group discussion methods. The process prevents the domination of discussion by a single person, encourages each group member to participate, and results in a set of prioritized solutions or recommendations.

The ADHS contractors used NGT in the initial phase of data collection to provide the structure for group discussions. These NGTs were conducted for both program providers and program clients in the three regions. In June 2005 a total of six NGTs were conducted; one in Flagstaff for providers and one in Prescott for clients (Northern Region), two in Phoenix (Central Region) and two in Tucson (Southern Region). In the Central and Southern regions one group was for clients and the other was adapted for service providers.

Information and responses from the NGTs were compiled and used to create a survey for community members. The survey, in both online and on-paper formats, was made available to diverse participants in both English and Spanish. The paper survey went to the three CPGs with locations and sampling determined cooperatively between Community Resource Associates and the Community Planning Groups. The online version was publicized as widely as possible using existing email lists.

Major Findings

During the NGT process, community members and clients identified the following **strengths** of Arizona's HIV prevention programs, resources and/or activities:

- Free and anonymous HIV testing
- Availability of testing, outreach to diverse populations
- Types of services, including counseling, housing and social activities

When asked about the **weaknesses** of Arizona's HIV prevention programs, resources and/or activities, client responses included:

- Lack of funding and inconsistency of funding
- Need for more outreach to the general population
- Local politicians and governments need more HIV information and education

A total of 205 client surveys were collected. Results from the survey of HIV prevention programs in Arizona indicate that clients have very good relationships with the staff in general, and that staff were seen as having a good knowledge base. Overall, clients trusted staff.

Strengths most frequently noted in the survey included:

- Coordination of referral services
- Comprehensive programs
- More involvement by partners/family members

When clients identified areas of dissatisfaction with prevention programs these included:

- Poor and limited funding
- Desire for better incentives

Feedback

In retrospect, the CSA process in 2005 was conducted with too little time. The consultants, although quite willing and interested in learning, were new to HIV/AIDS in general and had to learn processes, terminology and community players simultaneously. Strong plans for a wide-reaching survey met with unexpected challenges.

Shortly prior to this CSA there had been a chance that HIV prevention questions could be added on to statewide assessments from Care and Services. Despite a tremendous community effort, what could have produced extensive data was found to not be logistically possible. Many community members, especially in Phoenix, were aware of the attempt and saddened that what was seen as a "second best" CSA had to be conducted rapidly so shortly after learning that the first option could not happen.

As final challenges, the community planning CSA occurred at the same time as or just after other large surveys across the state and the reported "survey fatigue" contributed to low numbers. The Spanish language surveys presented their own challenges in the form of translation issues and difficulties in accessing monolingual communities.

Overall, the last CSA did not add much to the process of prioritization. However, each region already had knowledge of their HIV prevention activities and needs, and that knowledge transferred well into the new PPGA. At the point in the prioritization process when a planning group must consider data from a community service assessment, the PPGA had sufficient information from other sources to combine with this CSA and form the necessary decisions.

Future plans

As of the writing of this Plan there is a technical assistance request underway for a comprehensive Community Services Assessment of the PPGA and the three regions. ADHS will ensure that adequate time is allocated, and will be working with providers well-versed in HIV/AIDS in this area.

PPGA members have expressed interest in the experience of other jurisdictions that conduct assessments of specific populations during the middle years of a planning cycle. In learning how to best allocate time and effort in a longer span of years the group may choose to look at focused assessments between statewide comprehensive CSAs.

Other community assessments relating to HIV care, services and related topics are conducted periodically across the state and in different metropolitan or geographic regions. Community planning members are often involved in more than one area and there is time allotted for reports and collaboration when possible. A prime example are the HIV Care Planners distributed statewide in late 2007; these pocket-sized resource listings are mainly targeted to HIV+ individuals but are also quite useful for prevention resource listing and for staff and agency use.

ADHS staff and key community members have been involved in an assessment of the Black/African American communities across Arizona during 2007 with plans in place to continue through 2008. As issues relating to needs in this community arise in several sections of this Plan, the writers opted to centralize the discussion in one area. Please refer, therefore, to pages 30-31 for more on this assessment and related activities.

Section 7 – Prioritization process for populations and interventions

CDC's first goal supporting broad-based community participation in HIV prevention planning was addressed in Section 4. The final two of CDC's three main goals for Community Planning pertain to the prioritization of populations and interventions:

Goal Two: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

Three Objectives from the Guidance provide further details:

Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

Objective E: Ensure that priority target populations are based on an epidemiologic profile and a community services assessment.

Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended consumers for cultural appropriateness, relevance and acceptability.

The PPGA initiated its first prioritization process immediately after coming together as a group. This recent prioritization was Arizona's first experience with generating statewide populations. ADHS provided guidance at several points, including setting the format for population descriptors from both the regional groups and the PPGA.

The prioritization process that generated priority populations for 2007-2011 started with each regional group. Per ADHS guidance, each region used an adaptation of the prioritization process outlined by the Academy for Educational Development (AED) combined with local epidemiologic data and knowledge of area resources and needs. As described earlier, the RPGs had resource inventories and the CSA that was completed in 2005.

Each region was tasked with choosing a process that met ADHS guidance requirements and using their chosen procedure to list populations of the highest HIV prevention needs in their part of the state. The regional lists were submitted to the PPGA, and the membership of the PPGA used its own process (covered below) to generate statewide populations. The regions each completed a process of eliciting intervention modalities and prevention techniques best suited for their populations. ADHS staff used these extensive lists in the development of the Request for Grant Applications.

The use of "Impact Factors" in the planning process this cycle was a crucial and innovative change for Arizona. Provided by the ADHS epidemiologist, impact factors are numeric indicators for purposes of group comparison measuring the overall impact of an epidemic in a group. Simply stated, they assist in viewing the affects of the HIV epidemic on various communities in a way that makes comparisons valid and helpful to community members.

Regional recommendations

To illustrate formats and content of the regional input this section contains a chart submitted by the Forum from Northern Arizona and narrative listings from the Central and Southern groups.

Northern Arizona:

Northern Arizona submitted their list in table format showing the results of the AED weighting and scoring process. The Northern group recommended HIV+ individuals (per CDC mandate that HIV+ persons be ranked first), then MSM and IDU in designated counties within the region.

Factor	N=	Weight	Rank	Total
HIV +				
AIDS Incidence	3	3	1	3
AIDS Prevalence	0	3	2	6
HIV Incidence	188	4	3	12
HIV Prevalence	533	4	7	28
Impact Factor	201	5	6	30
Riskiness of behavior		2	8	16
Difficulty meeting needs		2	5	10
Barriers to reach		1	4	4
				109
MSM				
AIDS Incidence	39	3	1	3
AIDS Prevalence	113	3	2	6
HIV Incidence	57	4	3	12
HIV Prevalence	124	4	7	28
Impact Factor	1059	5	8	40
Riskiness of behavior		2	5	10
Difficulty meeting needs		2	4	8
Barriers to reach		1	6	6
				113
IDU				
AIDS Incidence	14	3	1	3
AIDS Prevalence	39	3	2	6
HIV Incidence	17	4	3	12
HIV Prevalence	38	4	4	16
Impact Factor	524	5	8	40
Riskiness of behavior		2	5	10
Difficulty meeting needs		2	6	12
Barriers to reach		1	7	7
				106

This input format is used here because it was the most focused and concise example showing the use of the AED process of identified, weighted and ranked factors. Additional information and presentation from the Northern chair to the PPGA elaborated on this data to make it similarly detailed to the following two lists and recommendations.

Central Arizona:

1. HIV+ Persons (all ages, ethnicities, genders) in Maricopa and Pinal counties
2. MSM (all ages, ethnicities) in Maricopa and Pinal counties
3. IDU and/or Hep C+ persons (all ages, ethnicities, genders) in Maricopa and Pinal counties
4. Black, Non-Hispanic Women (all ages) in Maricopa and Pinal counties
5. Individuals with an STD diagnosis (all ages, ethnicities, genders) in Maricopa and Pinal counties

And/or the partners of individuals above

Based on the new data on the rise of HIV infections among Black non-Hispanic women, the Central region also recommended the following:

- Develop a system to track federal and state funding awarded to address HIV prevention and/or care issues for Black non-Hispanic women and men in central region or the state
- Better coordination of service providers to this population regardless of funding stream
- Identify additional funding to address the continued rise in HIV infections in this population. Some of these funds should be allocated for research to better understand the specific HIV transmission vulnerabilities for this population

The Central group noted that more data is needed for the following populations of concern:

- Homeless individuals
- Incarcerated persons
- Persons diagnosed with a mental illness

Finally, the Central region recommended that ADHS work with other local and state departments to collect new data and organize this information to shed light on any correlation of vulnerability for all impacted populations. For example, data that cross references behavior, economic status, ZIP code, ethnicity and HIV cases would support their committee in better planning (interventions and funding).

Southern Arizona:

1. HIV + persons (all ages, ethnicities, genders) in the Greater Tucson metro area
2. MSM (all ethnicities) in the Greater Tucson metro area
3. IDU (all ethnicities, genders) in the Greater Tucson metro area
4. Hep C+ individuals (all ethnicities, genders) in the Greater Tucson metro area
5. Individuals with STD diagnosis (all ethnicities, genders) in the Greater Tucson metro area

And/or the partners of individuals above

SAHPPG also recommended that during the 2007-2011 cycle more research and data collection be directed at an additional list of populations in order to get a clearer perspective of their route of infection, infection rates and the magnitude of their needs. These groups included: non-injection drug using MSM, especially MSM who use methamphetamine; African Americans; members of ethnic groups that have demonstrated health disparities such as rural, tribal and border communities; incarcerated persons; homeless persons; persons diagnosed with a mental illness; non-injection substance users; and sex workers and people who have survival sex.

PPGA statewide priority populations

In December of 2005 the PPGA used input from the regions and epidemiologic data to select statewide priority populations. Final choices were described using parameters such as gender, HIV sero-status, behavioral risk and geographic location. The PPGA decisions were submitted to ADHS for review, and ADHS created a Request for Grant Application (RFGA) for the next planning cycle based on statewide target populations.

Arizona has identified the following target populations:

Persons living with HIV/AIDS statewide (first priority per CDC mandate)
Men who have Sex with Men (MSM) living in Maricopa County
Men who have Sex with Men (MSM) living in Pima County
Men who have Sex with Men (MSM) living in Coconino County
Men who have Sex with Men (MSM) living in Mohave County
Injection Drug Users (IDU) living in Maricopa County
Injection Drug Users (IDU) living in Pima County
Injection Drug Users (IDU) living in Yavapai County
Black non-Hispanic Women in Maricopa and Pima Counties *

*Black non-Hispanic women were addressed as a special circumstance and were not included in the grant process. This will be discussed in depth in the following Section 8.

Grant Process

ADHS shifted two key aspects of its grant procedures for this planning cycle. A five-year (rather than earlier three-year) time span was chosen, and a Request for Grant Applications (RFGA) process was used instead of the Request for Proposals used in earlier cycles.

Applicants for the grants were asked to suggest interventions (DEBI/EBI format) to be used with their selected target groups. The RFGA document contained information on effective interventions and on tailoring of interventions and ADHS made training and assistance available to applicants.

Funded programs and interventions

ADHS received strong submissions to the RFGA and the Health Department was able to fund four programs that addressed priorities, proposed strong interventions, and provided good geographic coverage for the state. The following providers were awarded grants by ADHS for the 2007-2011 funding cycle (interventions discussed below):

- Terros, in Phoenix, for Safety Counts programming serving IDU populations
- Body Positive, in Phoenix, for M2M programming to gay/MSM; this programming to be used in various regions of the state
- Southern Arizona AIDS Foundation (SAAF) in Tucson for an Mpowerment program
- SAAF for Methods, a Comprehensive Risk Counseling Services (CRCS) in various parts of the state targeting HIV+ individuals and selected partners

Counseling and Testing and Partner Services are implemented for all priority populations statewide.

The interventions being used by ADHS-funded programs for 2007-2011 are:

Mpowerment:

The Mpowerment Project was developed by and for young gay man ages 18-29. The intervention is run by a core group of 10-15 young gay men from the community and paid staff. The young gay men, along with other volunteers, design and carry out all

project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours.

Safety Counts:

Safety Counts is an HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.

This intervention works well with CDC's Advancing HIV Prevention initiative as it strongly encourages HIV testing as a precursor to program enrollment, clients can be recruited from testing programs, and sessions include a discussion of the importance of testing to the client. The intervention addresses the needs of both HIV-negative and HIV-positive clients.

Man2Man:

Man2Man is an innovative approach to long term HIV and STD prevention. The program consists of a sexual health retreat that strives to build relationships that promote physical, emotional and sexual wellbeing through the promotion of a healthy self-image and healthy behaviors. The Man2Man Program identifies and contacts individuals over 18 who are men who have sex with men, otherwise known as MSM, to enroll their participation in a two-day sexual health seminar.

Developed by Dr. Simon Rosser at the University of Minnesota, this National Model recognizes Body Positive as the sole Service Organization in Arizona to conduct Man2Man seminars. In addition to enlisting the general population of MSM, Man2Man is a culturally sensitive and appropriately adapted program for African American, Latinos, Native Americans and the Transgender community. Man2Man retreats are conducted twice yearly for each of these distinct diverse communities throughout Maricopa, Mohave, Coconino and Pinal counties, as well as eleven yearly general population retreats throughout the state.

Comprehensive Risk Counseling and Services:

(Formerly known as Prevention Case management) CRCS is an intensive, individual level, client-centered risk reduction intervention for people at high risk for HIV infection or transmission. CRCS providers are able to use other names for their programs and SAAF used "Methods" for CRCS activities in Arizona.

Section 8 – Goals and technical assistance opportunities

Arizona Department of Health Services

The overall and broad goals of the Office of HIV, STD, and Hepatitis C Services as stated in the Office's Strategic Plan are as follows:

- To educate and protect Arizonans at risk for HIV, STDs and/or Hepatitis C

- To promote optimal services and support quality of life for those Arizonans living with HIV/AIDS, STD infection and chronic hepatitis C
- To enhance data collection, public health surveillance, and health information technology
- To pursue proactive regulations, rules and policies in order to support quality public health services
- To address racial and ethnic disparities in the HIV/AIDS, STD and viral hepatitis epidemics in order to eliminate health disparities
- To enhance development capability and diversify funding across coordinated and integrated programs

Special focus on HIV Prevention to Black Communities in Arizona

As noted earlier in this Plan, Arizona has identified a special focus area and is working to assess and to address the greatly disproportionate impact of HIV on Black communities in the state. The following is a list of goals and projects compiled by ADHS. The Arizona Department of Health, HIV Prevention Program staff and partners will:

- Analyze a feasibility report completed from the University of Arizona to develop an intensive plan which will be used to determine the direction of counseling and testing and additional areas of focus for Black non-Hispanic women and their partners in Arizona
- Complete the first historical executive committee Black AIDS Task Force meeting to take place in Phoenix to collaborate, partner and mobilize Arizona's Black communities
- Conduct four Black AIDS Task Force Meetings with executive members to develop a plan designed to mobilize Arizona's Black communities to address HIV/AIDS and other sexual health challenges in Arizona
- Analyze and discuss evaluations and survey results from the Black AIDS Task Force meetings with the members and The Arizona Department of Health staff to address a plan for African American Programming in Arizona
- Continue to have capacity building efforts as a priority in Arizona's Black targeted populations in establishing and identifying better linkages with traditional and non traditional partners
- Participate in the 5th Annual Black History Month Celebration to address HIV/AIDS as well as STI and Hepatitis issues and their impact on the African Americans and health issues
- Attend and participate in at least six meetings with the African American Strategic Leadership Group (AASLG) which has established a health component which will focus on Health and HIV/AIDS issues in African American communities
- Provide information to the (AASLG) addressing HIV AIDS issues in the African American Communities along with other health agencies to educate the community of the impact and plan to action in the communities around health issues
- Participate in activities involving the Black Church Week of Prayer to address HIV/AIDS issues as well as the need for knowing your status and connecting to treatment if needed
- Attend the African American Legislative Days Conference (which has a focus on HIV/AIDS in African American Communities) and participate by providing a

workshop on HIV/AIDS issues and following up with additional collaborative issues

- Attend and participate in at least three town hall meetings (Phoenix, Tucson, Flagstaff and Sierra Vista) with The African American Commission working specifically with HIV/AIDS issues
- Work with the newly formed Center for African American Health to partner on HIV/AIDS issues which address issues in the Black Communities
- Provide a workshop on cultural competency issues in at least one regional advisory community planning group meeting
- Provide a presentation on cultural competency issues and HIV issues for Black AIDS Awareness Day at a Department of Corrections Task Force meeting
- Complete a HIV/AIDS workshop to address HIV/AIDS health disparities issues in Arizona at the Caesar Chavez Behavioral Health Conference
- Convene a meeting with Black researchers and behavioral scientists to begin to address issues, gaps, unidentified issues in dealing with HIV issues with Black non-Hispanic women and their partners in Arizona
- Convene ongoing meetings with staff members of Mid Western University to identify and select topics for potential focus groups with Black and other at risk populations; with a focus on identified gaps as they relate to prevention issues

Community Capacity Building Goals:

The goals of the Office's capacity building efforts are to:

- Develop and support the HIV prevention infrastructure throughout Arizona.
- Improve agency and organization performance in the areas of program development, implementation, and evaluation.
- Strengthen the infrastructure of Arizona's rural areas to increase their capacity for providing HIV prevention services.

Activities include:

- Identify those agencies/programs not presently active in community planning
- Identify the barriers that disallow these agencies from participating, by creating working relationships with the state non-funded agencies. Barriers to CPG participation will be a crucial area of concern.
- Coordinate linkages between non- participating agencies/ programs and participating CPG agencies.
- Link agency/program to resources. By linking agencies/programs with public/private business/corporations/other government agencies via meetings, presentations, public forums.
- State Health Department will continue to participate in a statewide Faith Initiative, bringing AIDS prevention and service agencies/programs together with the faith communities.

PPGA Goals

Goals stated by the full statewide planning group include:

- Targeted recruitment for membership with focus on PIR gaps as described in Section 4 of this Plan
- Completion of a working draft of the 2007-2011 Comprehensive HIV Prevention Plan; continuation of a work group dedicated to ongoing updates and refinements using the Plan as a living document
- Designate timeframes and dates for key community planning activities for the 2007-2011 planning cycle

Regional goals

Projects and goals common to the three regional groups for 2008 include:

- Assessment of still-existing gaps in HIV prevention delivery; focus on regional needs not addressed by ADHS funded programs; discussion and planning for possible ways to address these identified gaps
- Creation of working plans for sustainability of the groups as means of providing regional input to the PPGA and area-focused HIV prevention activities and community education
- Continued work with ADHS to request and obtain technical assistance as needed
- Increased and ongoing outreach to and work in the communities; examples include collaborative training opportunities and participation in community events relevant to HIV issues

Technical assistance opportunities: received

The following TA requests were submitted through the CRIS system at the CDC and have been completed within the past year. There is a high degree of satisfaction reported from all audiences and recipients. Listed from the most recent back:

- From the Inter Tribal Council of Arizona (ITCA) and National AIDS Education and Services for Minorities (NAESM), a one-day workshop in Phoenix for members of the Central Arizona HIV Prevention Advocates and community members: Cultural Competency with African Americans in HIV Prevention
- With Council of Community Clinics (CCC) Project SMART, a two-day presentation and focused work with providers on social marketing
- The Behavioral and Social Science Volunteer Program (BSSV) arranged work with Terros in Phoenix on development of an evaluation tool
- Arizona-Mexico Border Health Foundation worked with the Southern Arizona HIV Prevention Planning Group to plan and deliver three trainings on different topics to the rural parts of the Southern region
- Arizona-Mexico Border Health Foundation worked with the HIV Prevention Manager at ADHS to compile health education/risk reduction (HE/RR) tools available for us in program evaluation
- Arizona-Mexico Border Health Foundation provided a cultural competency training for the Maricopa County Health Department in Phoenix

- Council of Community Clinics (CCC) Project SMART assisted with a Social marketing training in Phoenix

Technical assistance opportunities: in process and planned

Arizona has the following TA requests and projects in process for 2008:

- National Safety Counts training in Phoenix
- Social Marketing training
- Social Networks in Testing training to be held in Phoenix
- A comprehensive Community Services Assessment of the PPGA and the three regions
- Training for the regional groups on the process of formulative evaluation
- Interest in partnering with the US-Mexico Border Health Association; the state co-chair has attended an advanced ENLACES training with USMBHA
- Ongoing discussions with local representative from the Behavioral and Social Science Volunteer Program on assessment opportunities within community planning
- Work in progress with a local researcher interested in conducting research projects that will benefit planning processes

Section 9 - Evaluation

Evaluation of HIV prevention efforts requires a group effort on the part of all stakeholders - prevention providers, community planning group members and leaders, staff of statewide health departments, consumers, and others. As the lead agency and fiscal agent for CDC HIV prevention funding, Arizona Department of Health Services' HIV prevention program is ultimately responsible for the collection, analysis, and reporting of evaluation data to all interested parties. In addition, the Health Department provides support, education, training, linkages, tools, and funding in order to facilitate evaluation of prevention activities throughout the state.

At present, Arizona's primary evaluation priorities continue to focus on increasing statewide capacity and implementing a user-friendly system for collection and analysis of CDC-required process monitoring data. ADHS has also worked to maintain and increase support for evaluation activities among HIV prevention stakeholders: within the Health Department itself, by the PPGA and the three regional planning groups, and by individual prevention contractors and county health departments. The achievement of the Plan's broad goals will provide a foundation for evaluation, which can be supplemented and enhanced in future planning cycles.

The 2007-2011 Plan's goals and objectives will further the following purposes of evaluation:

- Maintain support for evaluation among all prevention stakeholders
- Promote prevention program improvement
- Encourage grantee self-management and benefits from evaluation activities

- Facilitate contract monitoring and grantee accountability
- Provide opportunities for technical assistance, education, and other health department support of prevention activities
- Fulfill CDC process data collection and reporting requirements, including PEMS implementation, while minimizing the impact of these changes on local providers
- Yield data, which can be shared with and compared to findings from other programs
- Suggest future directions for evaluation by State Health Department and its grantees
- Contribute to the overall quality and success of HIV prevention efforts throughout Arizona

Evaluation of HIV prevention community planning will be conducted using information provided by CDC in the newest Guidance and Process Evaluation and Monitoring System (PEMS) implementation planning materials. As changes are made with PEMS requirements, the PEMS Work Group will monitor the potential impact of new requirements on local planning groups and processes and formulate updated evaluation plans and activities. Focused needs assessments are being conducted on additional priorities with populations of concern to determine how best to direct prevention activities for greatest impact. In addition to evaluation instruments mandated by CDC, the statewide Work Group is studying other means to assess meaningful aspects of the community planning experience for state and regional members.

Internally ADHS is working in several areas to implement and improve evaluation functions. These areas include:

- Improving monitoring capabilities; for example, improving site visit functions with targeted programs to better assist with program improvement
- Working with targeted programs to have applicable quality assurance plans in place and to meet regularly to go over evaluation activities, needs and uses of results for program improvement
- Sharing CTR monitoring duties among health department staff to better perform the monitoring capabilities based on types of CTR programs
- Monitoring the PPGA and regional planning groups on the extent to which they impact the state or regional communities; starting a dialog with the community planning and advisory groups around developing a quality assurance committee that could assist the HIV prevention program in looking at gaps analysis, needs assessment and programs which are designed or funded to meet those needs

TA requests have been made during 2007 which are continuing into 2008. These are being done with one of the targeted programs for program evaluation, with the PPGA for evaluation of processes and internally for site visit reform. As envisioned at this date the PPGA request will be used to generate a comprehensive Community Services Assessment as well as an assessment of internal statewide and regional planning group processes.

Further TA requests will be made for adaptation, group facilitation and other focus areas as needed to improve programs in the jurisdiction. Each type of program funded will be assessed for their own training needs and the health department will assist those

programs in obtaining training or other quality assurance activities. For example: in order to assure an ongoing QA process is in place and that services are as well-planned and comprehensive as possible, CRCS staff have been provided with training in the CRCS model, motivational interviewing, stages of change, cognitive behavioral theory, treatment planning, group facilitation and outreach training. Programs will be evaluated on their use of such training and on the program success to determine that staff is adequately prepared.

ADHS will continue to implement an electronic, web-based system for collecting client-level data in accordance with all PEMS requirements including those for quality and security of data. The department continues to contract with Luther Consulting for web-based data collection of all CTR and targeted behavioral interventions. This data is used for monitoring and evaluation of programs for both process and outcome. As ADHS has been using the behavioral questions outlined in PEMS, staff are better able to look at behavioral change within the programs. ADHS is also working with the Program Evaluation Branch of CDC to access CPEMS (meaning that some, but not all of PEMS is utilized) for submission of agency and budget data. This will allow the state to better meet the needs of all stakeholders and evaluate program activities and design.

Section 10 – Linkages

The ADHS Office of HIV, STD and Hepatitis C Services includes in its Guiding Principles the statement that it “regularly embraces community participation through community planning processes, stakeholders, and working collaboratively with community partners.” One of the stated Values of the office states that ADHS staff members actively seek out opportunities for collaboration and the sharing of information and knowledge within the Department, the Office and with its partners. This final Section will outline key linkages both within ADHS and as created and maintained by HIV Community Planning processes in the state.

Integration and collaboration within ADHS – General and historic

The recent integration of the HIV/AIDS, STD and Hepatitis C programs is the most significant new development within ADHS between the last planning cycle and the present. Internal linkages in administrative support and data (including epidemiology) are in place. Programmatic issues are now being addressed with a view towards cooperation when practical. For example, the Central HIV prevention regional planning group has had meetings with ADHS staff and members of the HCV Coalition to explore ways that the two groups can work together with support from both HIV prevention and HCV staff members.

Current integration is built on a history of changes within the health department. The STD and HIV programs had been formally merged as the Office of HIV/STD Services from 1994 until 2002. In 2002 STD and Hepatitis C programs were moved to a separate office. The HCV Prevention and Surveillance program, started in 1999 as a part of the HIV program, became its own entity in 2002. While the three related but internally segregated groups have a history of working together, the new officially recognized configuration is proving to be beneficial both internally and externally.

The previous Office Chief of the HIV/AIDS program was maintained briefly after the integration in his additional role of State AIDS Director. As that individual has left state employment, the new Office Chief for HIV, STD and HCV now acts as Arizona's State AIDS Director. With her experience and tenure at ADHS she is becoming an advocate for integration of services on a regional and national level.

ADHS is also involved with degrees of integration within and among various planning bodies. The main HIV example is the shift to a single CPG. The RPG for Northern Arizona is a combined Care/Prevention body. Groups relating to HIV Care and Services, Hepatitis, and American Indian HIV issues have utilized ADHS support.

Integration and collaboration within ADHS – Specific

Several areas of collaborative focus for the HIV Prevention program are noted here. While this is by no means an exhaustive listing it does provide a sense of the scope and variety of linkages. HIV Testing is a primary component of the HIV prevention program and as such the segment below is extensive. Other linkages noted less comprehensively below each contribute to the success of the HIV Prevention program.

Counseling, Testing and Referral (CTR) Services

Arizona has a system that supports county health departments and agencies as they report testing activities that focus on diagnosing as many new cases of HIV as possible. Routine testing, or testing in county health department units that do not see priority populations (for example TB or family planning) report only the preliminary positives through their prevention programs. The more targeted CTR targets those at most risk for HIV in Arizona: partners of HIV positive persons, gay men/men who have sex with men, injection drug users and their sexual and/or needle sharing partners. Currently, CTR sites are operating programs using two different guidance documents: the CDC Revised Guidelines for HIV Counseling, Testing and Referral MMWR 2001 and the 2006 HIV Testing in Health Care Settings. This balancing of guidances does present some challenges for providers, and ADHS is able to provide technical assistance as needed to meet individual circumstances.

All persons receiving confirmatory testing in the CTS program also receive testing for Hepatitis C and Syphilis. This allows the individual to be linked to appropriate health care with a more complete set of results. All providers of HIV testing either directly or indirectly (through referral) offer STD and TB screening on all preliminary positive rapid tests. In addition, samples are sent to a CDC contracted lab for the Incidence program.

Rapid testing is now available at all county health departments and agencies that report testing activities through ADHS. The use of rapid tests has improved HIV test result return rates to almost 98% in clients who test positive in publicly funded sites. ADHS collaborates with AIDS service organizations (Body Positive, SAAF) that serve gay/MSM populations, and with SAMSHA funded sites (Terros & COPE) serving IDUs and their partners, and with county health departments. The County Health departments are directed by statute to be the providers of Partner Services activities.

Integration and collaboration within ADHS – Continued

Additional areas of collaboration within and initiated by ADHS include:

- **Sexually Transmitted Disease program:** STD testing available for those with preliminary HIV+ tests; Infertility Prevention Program; a targeted MSM/syphilis outreach program is in initial stages; work on syphilis outbreak response
- **Hepatitis C and viral hepatitis:** Provision of HCV testing and hepatitis A and B vaccination to clients enrolled in the Terros Safety Counts program; collaboration between HIV personnel and the Arizona Hepatitis C Coalition
- **TB:** Data matches for positive tests; sharing of resource guides
- **Women's and Children's health:** Specific collaboration in place with the ADHS Comprehensive school sexual education coordinator; assistance at event; provision of materials; work on syphilis outbreak response
- **Behavioral health:** SAMHSA-funded programming supports HIV testing in behavioral health settings

ADHS HIV Prevention staff also work with many entities, events and communities across the state:

- Continue to collaborate with corrections and criminal justice programs through community planning participation, educational materials and supplies provision and ongoing direct contact to address issues or concerns as they arise
- Collaborate with agencies funded by the health department for targeted behavioral interventions to plan trainings and capacity building experiences to enhance their skill and knowledge, improving the delivery of services to the targeted communities
- Attend regular meetings of several community groups including the HIV/AIDS Correctional Task Force, the Arizona Hepatitis C Coalition, and the Arizona American Indian HIV Prevention Task Force
- Continued collaboration with community agencies, both funded and non-funded, in the planning and implementation of community events including National Testing Day, the various HIV Awareness days, AIDS Walk and World AIDS Day

In closing

This 2007-2011 Comprehensive HIV Prevention Plan is in itself a tool for linkages and collaboration. Reviews of this document will continue to shape, report on and create the interconnections that make HIV prevention community planning strong in the state of Arizona.

Community Planning staff and group members will work with ADHS at the beginning of calendar years 2009-2011 to draft comprehensive updates. This Plan will also provide a base for the next planning cycle as the state's HIV prevention activities adapt and respond to national guidance.

The intent is that this document will be read, used, added to and elaborated upon: may it continue to reflect both the diversity of our state and the dedication of our communities.

ATTACHMENTS

ATTACHMENT A

**Bylaws of the HIV Prevention Planning
Group of Arizona**

ATTACHMENT B

Letter of Concurrence

ATTACHMENT C

Statewide Guidelines for HIV Prevention Community Planning in Arizona

ATTACHMENT D

Community Services Assessment

ATTACHMENT E

Office of HIV, STD and Hepatitis C Services

Strategic Plan 2008-2012